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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 170 SS=B	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This Requirement is not met as evidenced by: The facility reported a census of 27 residents. Based on interviews, the facility failed to deliver mail to the residents on Saturdays. Findings included: - On 12-17-14 at 8:37 a.m., resident #2 stated, mail is not delivered on Saturdays. On 12-17-14 at 1:03 p.m., resident #22, stated that he/she would want to receive mail on Saturdays. On 12-17-14 at 1:07 p.m., resident #28, stated he/she would want to get mail on Saturdays if he/she had any. On 12-17-14 at 1:11 p.m., resident #1, stated he/she would like to get mail on Saturdays if it still came on the other days of the week. On 12-17-14 at 9:09 a.m., social services staff C stated, the post office is open on Saturdays, but mail is not delivered on Saturdays to the residents. On 12-17-14 at 9:24 a.m., administrative staff I	F 170		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 170	Continued From page 1 stated, the mail is picked up from the post office by the engineering department and brought to the hospital. It is delivered to the nursing facility and delivered by staff. It is not delivered on Saturdays, even though the post office is open until noon. On 12-17-14 at 10:10 a.m., administrative staff L stated, the post office box is at the post office and is picked up two times a day, Monday through Friday. Resident mail comes to long term care one time a day. Mail is delivered to the residents by volunteers or staff. The facility lacked a policy regarding mail delivery to the residents. The facility failed to deliver mail on Saturdays to the residents of the facility.	F 170		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This Requirement is not met as evidenced by: The facility reported a census of 27 residents, with 15 selected for review. Based on observation, interview and record review, the facility failed to provide individualized activities for 3 of the 3 sampled residents reviewed for activities (#26, #12, and #18). Findings included: - Review of resident #26 physician orders, dated	F 248		

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F 248	Continued From page 2 11/4/15, documented the resident admitted on 7/1/13, with the following diagnoses: Down's Syndrome (chromosomal abnormality characterized by varying degrees of mental retardation and multiple defect), blindness, and dementia (progressive mental disorder characterized by failing memory, confusion) with behavior disorder. The annual MDS (minimum data set), dated 7/9/14, revealed the resident had highly impaired vision, and wore corrective lenses. The resident with short/long term memory problem, and severely impaired decision making. The resident interview for activity preferences revealed the resident determined it was very important to listen to music he/she liked, be around animals, such as pets, do things with groups of people, do the residents favorite activities, go outside to get fresh air when the weather is good, and participate in religious services or practices; and was not important to have books, newspapers, and magazines to read, and keep up with the news. The resident required extensive staff assistance for walking and locomotion; limited staff assistance for transfers and used wheelchair for mobility. The CAA (care area assessment), dated 7/15/14 for cognition documented the resident with a diagnosis of Downs Syndrome and associated dementia. The resident has been showing the ability to recall some of the staff names. Dementia is associated with Down's syndrome in later years of life, and can expect to see a continued decline. The CAA for vision revealed the resident is legally blind, however the resident can see outlines and shapes, but not much else. The CAA for ADL's included the resident required guidance with transfers and ambulation.	F 248		

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F 248	Continued From page 3 The CAA for Activities did not trigger. The quarterly MDS, dated 10/9/14, revealed no changes from the prior MDS. The care plan, reviewed on 10/14/14, advised for impaired memory to provide task segmentation for the resident to allow completion of direction. The care plan lacked a individualized activities for this resident with special needs related to blindness and Down's syndrome. Review of the initial activity assessment, dated 7/9/13, documented the resident's past activity interest was music, watching television, enjoys older cartoons and older television shows. The resident was kind of a loner, his/her hobby used to be an Elvis fan, movies, and cartoons. Current Activity Interests: music, and watching television. Activity time preferences: the resident was a late riser, and prefers activities in activity room. Review of the quarterly Activity Assessment, dated 1/21/14, documented the resident does participate in pen pal time. The resident was unable to do arts and crafts himself/herself but does appear to enjoy the interaction of being with others while these activities are being performed. The resident participated in bingo, during weekly bingo the auxiliary volunteer staff will work one on one in helping the resident play bingo. The resident appears to enjoy this activity. The resident participated in resident council, care plan meetings, and bible study. The resident participated in outings (a van ride). Furthermore, special meals or dinner parties at the facility, birthday parties, and holiday dinner. The resident will participate in sports exercise. For spiritual/religious activity, the resident enjoys	F 248		

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gospel music. The resident participated in other activities: one to one, independent activities, and men's coffee. The resident appears to enjoy spending time with the facility bunny rabbit. The facility purchased a new CD (compact disc) player for his/her room. The resident appeared to enjoy the interaction with staff in a very positive way. Volunteer/Staff Services: hair care, manicures, grooming, and shopping. Factors Affecting Participation: illness, vision, and cognition. For behavior: when the resident first came to live here he/she had many different behavior issues. The resident now laughs and appears to be very happy.

The December, 2014, Activity Calendar documented the following activities:

On 12/15/14, one on one exercises (no time listed),
At 10:00 AM, bingo, and 1 on 1 exercises. However, the resident remained in his/her room.
At 1:30 PM, one on one visits. However, the resident remained in his/her room.
At 2:30 PM bible study, and at 3:00 PM small group. However, the resident remained in his/her room.

On 12/16/14, one on one exercises (no time listed).
At 9:30 AM, card bingo. However, the resident remained in his/her room.
At 10:30 AM, large group exercises, and again the resident remained in his/her room.

Observations revealed on 12/15/14 at 10:00 AM, a group played bingo in the dining area the the resident was not included in the group. Furthermore, the resident not included in the one on one activities at 1:30 PM or the group for bible

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F 248	Continued From page 5 study at 2:30 PM. Observations revealed on 12/16/14 at 9:14 AM, the resident sat in his/her wheelchair in his/her room, in front of a bedside tablet holding a stuff animal. The door to the residents room was halfway closed and the resident's CD player not turned on. At 10:26 AM, the resident remained unchanged. On 12/16/14 at 2:20 PM, the resident sitting in front of the window in his/her wheelchair holding a stuffed cat in his/her hand. The resident's side of the room contained a CD player, approximately 10 CD's, and also numerous DVD 's and a set of head phones lying beside the bed. The CD player was not turned on. On 12/16/14 at 3:40 PM, the resident back in his/her room, in his/her wheelchair, in front of the window holding a stuffed cat, and at 4:15 PM, the resident remained unchanged from the previous observation. On 12/17/14 at 8:30 AM, the resident sat in his/her room in front of a bedside table in a wheelchair, holding a stuffed cat. There was not any music playing, and at 9:30 AM, and 10:19 AM observations revealed no change in the resident. On 12/16/2014 at 12:52 PM, activity staff C stated he/she visited with the resident and his/her family members to see what his/her life was like. The resident's family member informed staff the resident liked to watch Walt Disney movies, however the resident can become excitable and may need taken out sometimes. The staff tries to adapt games for the resident. Staff C stated he/she tries to remember to chart if a resident attended an activity, but if not, he/she will	F 248		

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document in the quarterly assessment. The resident likes to hold the facility rabbit, and the facility recently bought for the resident a new stuffed animal and a CD play to listen to music. Staff C stated he/she has a volunteer who will spend time with the resident and he/she does one on ones 2 times a week. The staff know what to do for the resident from the care plan.

On 12/16/2014 at 2:20 PM, the resident answered yes when asked if he/she liked to sit in the sun, and does like to listen to music, however was unable to state what kind of music, the resident liked.

On 12/16/2014 2:25 at PM, direct care staff J stated the resident will usually let us know what activities he/she likes or dislikes. The resident does not come out for bingo,but will come out for singing, during church. Sometimes the resident comes out for exercises and then becomes over stimulated and will have to bring the resident back to his/her room. The resident usually or his/her roommate will usually have the radio on, today though neither one has the radio on. The resident has a care plan, and if the care plan is new the staff reads through it and signs it.

On 12/16/2014 at 12:53 PM, activity staff C stated when a resident is admitted to the facility, I will do an initial assessment, then quarterly and yearly assessment. I will ask the resident and their family what the resident likes, and what his/her normal routine in regards to activities. Staff C does not chart daily on what the residents are participating in, he/she only charts on the quarterly and yearly assessment.

On 12/16/2014 at 1:47 PM, direct care staff D reported a resident wants to go to an activity, the

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direct care staff will make sure the resident was dressed and toileted. If the resident wanted a specific activity on another shift, the staff would communicate that information during shift change report. A CNA (certified nurses aide) on the floor will do the activity if the AD (activity director) is not able to.

On 12/17/14 at 8:45 AM, activity staff C stated he/she did an assessment in January, 2014, and the resident was due for an annual assessment in July, 2014, however he/she evidently did not do one. Furthermore, staff C does quarterly assessments when administrative nursing staff A gives him/her a schedule of when they are due.

On 12/17/14 at 10:44 AM, direct care staff E stated the resident will hold his/her stuffed animal, likes to look out the window. Staff E will turn on music for the resident. Furthermore, staff E knows what to do for the resident from the care plan and the resident will ask the resident.

On 12/17/2014 at 9:12 AM, activity staff C stated the resident did not receive any one on one on 12/16/14.

On 12/16/2014 at 2:47 PM licensed nursing staff B stated the resident likes the rabbit, but can not place the resident too close to the rabbit because of a allergy. The resident likes to listen to music.

On 12/17/14 at 8:42 AM, administrative nursing staff A state he/she did not see any further activities assessments in the computer, nor is there a care plan for activities because the activity CAA did not trigger. Furthermore, stated the facility has 30 residents, the CNA's know of activities by word of mouth or the communication book.

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F 248	Continued From page 8 On 12/17/2014 at 2:06 PM, licensed nursing staff N stated the resident held stuffed animals, and plays a lot of music, especially at night. The resident will come out for singing activities. The residents roommate has the radio on every night. The staff also open the blinds for the resident to look out. Staff N verified he/she reviewed the care plan and they are updated. The undated facility Comprehensive Assessment and Care planning Policy, documented for scheduling the care plan will be completed on admission (within 14 days). An individual care plan will be developed/reviewed for each resident with documented measurable goals and outcomes within 7 days from completion of their MDS assessment. The RAI (resident assessment indicator) process (MDS & CAAS) is the basis for care plan decision making. This decision will be made by the RN (registered nurse) coordinator but is a combined effort of the members of the interdisciplinary team. The facility policy for activities program, dated 10/19/04, documented the resident will be assessed upon admission, and a minimum of quarterly during the comprehensive assessment. This assessment will determine the amount and types of interests and activities that the resident currently pursues, as well as activities the resident would like to pursue that are not currently available at the facility. In addition, it will assess the resident's preferred activity settings, and which activities the resident would prefer to participate in (independently or with others). Once this is done, and individual activity plan will be developed. The documentation of the resident's daily attendance at activities will be documented on the Activity Participation Form and maintained	F 248		

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in the Activity Director's office. Documentation for activity progress will be made quarterly in the Social Services Progress Notes section of the resident's chart.

The facility failed to provide individualized activities for this resident to enhance the resident's highest practicable level of physical, mental, and psychosocial well being.

- The resident (#12) diagnoses when admitted on 10/25/13, found on the signed POS (physician order sheet) dated on 11/4/14, included: Alzheimer disease (progressive mental deterioration characterized by confusion and memory failure), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), and HTN (Hypertension- elevated blood pressure).

The residents annual MDS (minimum data set), dated on 11/4/14, revealed the resident had adequate hearing and vision. The resident was understood by others and understands others. The resident had a BIMS (Brief interview of mental status) score of 6, indicating the resident had moderately impaired cognition. The resident had a mood score of 4, indicating the resident had minimal depression. The resident wandered daily and intruded on the privacy of activities of others. It was not very important for the resident to read books, newspapers or magazines. It was somewhat important to listen to music, doing things with groups of people and participate in religious services. It was very important to be

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around animals such as pets, doing his/her favorite activities, and get outside to get fresh air when the weather is good, and not important to keep up with the news. The resident was independent with bed mobility, required supervision with transfers, and required limited assistance of 2 staff with walking, ambulation, and dressing.

The MDS did not trigger for activities from the assessment dated on 11/4/14.

The residents CAA (care area assessment) for cognitive loss/dementia, dated on 11/8/14, revealed the resident had a diagnosis of Alzheimer disease and had moderate/severe cognition impairment. The resident wanders in the wheelchair most of the time. The resident had past history of behaviors such as striking and insulting others, but had not been an issue for at least last 90 days.

The clinical record is lacking CAA for activities due to the activities not triggering from the annual MDS dated on 11/4/14.

The plan of care, updated on 11/14/14, revealed the resident needed task segmentation to allow completion of directions and reorient to surroundings PRN (as necessary). The resident was to attend morning announcements for orientation and redirect the resident if displaying frustration or behaviors to degrees agitation. The staff are to do activities with the resident to decrease risk of anxiety and wandering. Invite to activities daily and encourage participation in the morning announcements. Remind and encourage resident to attended activities that the resident particularly enjoy. Provide room visits when the resident was not going to activities. Respect the

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residents right to refuse, offer activities as choices between two events. The quarterly activity assessment will be documented to update the residents interests. Encourage the resident to attend activities like silverware wrapping and others which he/she might appear to be able to volunteer his/her services.

The activity calendar for December, revealed planned activities on 12/16/14:
One on one exercises un-timed, and this resident remained in bed
9:30 AM - Card bingo, and this resident remained in bed.
10:30 AM - Large group exercises, and the resident refused due to getting up.
1:30 PM - Care plans, which are not resident activities.
3:00 PM ball toss, which the resident refused.

On 12/17/14, the following activities scheduled for the day;
9:30 AM - Small group (B &D), and the resident remained in bed.
un-timed, one and one activity, the resident was in bed.
un-timed, nail care, the resident was in bed.
un-timed mini fit group, and the resident remained in bed.
2:00 PM - Silverware wrapping.
3:00 PM - Lets sing Christmas music and decorate Christmas cookies.
3:00 PM - Small group (A&C).

The activity assessment, dated on 11/13/14, revealed past activity interests included; cards, rummy, games, Chinese checkers, crafts/arts, woodworking, sports, swimming, music, religious activity, watching TV, current activity interest are cards, visiting possibly one on one, music walking

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outdoors, watching TV. activity time preferences are in the morning, the resident likes to get up early in the morning, and prefer outside activities.

The residents clinical record lacked any quarterly activity assessments since admission, which administrative nursing staff A confirmed.

On 12/17/2014 at 2:22 PM, the resident is sitting at the front door, looking out the door while the silverware wrapping was in progress in the dining room.

On 12/17/14 at 3:15 PM, the resident is wandering the halls in his/her wheelchair, propelling self while the Christmas music and cookie decorating was in progress in the dining room.

On 12/17/2014 at 1:19 PM, the resident's family member, stated the residents cognition had declined, and he/she was not interested in doing what he/she used to do. Activity staff C tries to engage the resident, but activity staff C needed a full time assistant to help with the activities.

On 12/16/2014 at 12:53 PM, activity staff C, stated when the resident is admitted to the facility, he/she will do an initial assessment, then quarterly and yearly assessment. He/she will ask the resident and their family what the resident likes and what their normal routine in regards to activities. He/she does not chart daily on what the residents are participating in. He/she only chart quarterly and yearly. He/she tries get to engage the resident in anything. The resident does not stay engaged for very long. The resident will set and watch someone else do activities but will not participate. The resident likes to go up and down the halls in the wheelchair. The resident does not

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seem interested in anything. The staff have tried to reminisce, look at picture books and go through a trinket box. The resident is very sensitive with his/her hearing. The resident likes to lay down a lot. It varies on how often he/she participate. The staff will ask him/her and encourage him/her to come to activities. The resident does not like to be in him/her room unless he/she is sleeping, the resident likes to be by himself/herself, if he/she is not participation with activities the staff.

On 12/18/2014 at 8:43 AM, activity staff C, stated he/she had no excuse for why the quarterly did not get done. He/she think that it is more important to assist the aides on the floor then to get the paper work done. He/she really did not have any time to do the assessments, between the scheduled activities, transportation and assisting on the floor, he/she could not keep caught up on them.

On 12/16/2014 at 1:47 PM, direct care staff D, stated If the resident wants to go to an activity, the staff will make sure the resident was up, dressed and toileted. If the resident wanted a specific activity on another shift, the staff would communicate that in shift change report. The resident needs direction to the activity, he/she likes wandering in his/her wheelchair. Sometimes we do have to help. the resident loses interest, and we have to keep him/her directed to the activity. the resident likes putting together puzzles. The resident can get very irritated and confused. The resident is invited to the activities, but he/she will not stay. There are no activities to keep his/her attention with the activities, the only time was when his/her family was here.

On 12/17/2014 at 2:56 PM, direct care staff G,

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stated the resident will come out to the movies, the staff assisted the resident to the activities. The resident does not refuse the activities unless he/she is asleep. The staff will go to the residents room and ask the resident if he/she would like to attend the activity.

On 12/18/2014 at 9:46 AM, direct care staff M, stated the staff will take him/her into the activity, but then he/she will leave. The residents attention span was very short. The resident wanders most of the time. The staff asked the resident to come to every activity. The resident will come and not stay long, but if he/she is sleeping, he/she will not come.

On 12/16/2014 at 2:47 PM, licensed nursing staff B, stated the resident has a very short attention span. The resident had dementia and it was hard for the resident to pay attention. The resident really likes pop corn and watching a movie. If the resident refuses anything he/she had the staff tell the nurse, so that another approach could be tried with the resident. The staff made sure that auxiliary staff is to assist with activities, when there is a big activity, he/she will schedule a CNA on the floor to assist and leave 2 staff on the floor to answer the call lights when the activity department needed assistance.

On 12/17/2014 at 3:09 PM, licensed nursing staff N, stated the resident has a short attention span, the staff will take the resident to the activity and with in a couple of minutes the resident will leave. The resident enjoys church and singing. The staff will let the residents know when an activity is going on. The resident wanders all the time. The resident will be up late at night wandering, then the resident will sleep all day.

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F 248	Continued From page 15 On 12/17/2014 at 12:09 PM, administrative nursing staff A, stated he/she was able to find the residents initial assessment from the residents admission, but he/she could not find any evidence of any quarterly activity assessment. The activity director needs to be charting that the residents are participating in an activity quarterly and daily. The quarterly assessments should be done when the care plan meeting was being discussed. The facility activity policy, dated on 10/19/04, revealed that each resident will be assessed upon admission, and a minimum of quarterly during the comprehensive assessment. This assessment will determine the amount and types of interests and activities that the resident currently pursues, as well as activities the resident would like to pursue that are not currently available at the facility. In addition, it will assess the resident's preferred activity settings and which activities the resident would prefer to participate in (independently or with others). once this is done, an individual activity plan will be developed. The documentation of the resident's daily attendance at activities will be documented on the activity participation form and maintained in the activity director's office. documentation for activity progress will be made quarterly in the social services progress notes section of the resident's chart. The facility failed to provide an individualized activity program that met this cognitively impaired and dependent resident's physical, mental and psychosocial needs. - Review of the physician order sheet, dated	F 248		

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F 248	Continued From page 16 11-07-14, revealed resident #18, admitted to the facility, on 9-15-11. The Significant Change MDS (minimum data set), dated 5-31-14, revealed the resident unable to complete a BIMS (brief interview for mental status). The staff interview revealed the resident with memory problems of both short and long term memory loss. The MDS also revealed it is very important to have family or a close friend involved in discussions regarding care, to listen to music and to do things with groups of people. The CAA's (care area assessment), dated 5-31-14, did not trigger activities. The care plan, dated 12-03-14, directed staff to bring the resident to large group exercise for social interaction. The quarterly activity assessment, dated 9-24-14, documented the resident participated in arts and crafts and also enjoys pen pals (a group of fifth graders who visit the residents) are at the facility. On 12-15-14 at 11:50 a.m., the resident was resting in bed in his/her room while a group activity was going on in the dining room. According to direct care staff F, the resident had not been invited to participate in the activity. On 12-16-14, at 3:30 p.m., the resident was resting in bed with eyes closed, while a group activity of ball toss proceeded in the dining room. The resident's television was tuned to a game show. On 12-16-14 at 10:24 a.m., direct care staff K stated, the resident no longer participated in group activities and does not do activities in	F 248		

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F 248	Continued From page 17 his/her room. On 12-17-14 at 11:15 a.m., the resident's family member stated they would like for the television in the resident's room to be left on the Hallmark channel. On 12-17-14 at 12:59 p.m., direct care staff D stated, the resident does not participate in activities outside of his/her room. On 12-16-14 at 12:53 p.m., activity staff C stated, the facility does an initial activity assessment at the time of a resident's admission. After that, a quarterly assessment is done. Staff C continued to state that staff do not chart each activity a resident does but the staff may get them added to the quarterly or yearly assessment. Staff C stated the resident typically just likes to watch television. On 12-18-14 at 8:05 a.m., administrative nursing staff A, stated he/she feels the facility should explore more options for activities for this resident. The facility policy for activities, effective 10-19-04, indicated documentation of the resident's daily attendance at activities will be documented on the Activity Participation Form and maintained in the Activity Director's Office. The facility failed to provide individualized activities to meet the needs of this dependent resident.	F 248		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	F 279		

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F 279	Continued From page 18 comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This Requirement is not met as evidenced by: The facility reported a census of 27 residents with 15 selected for review. Based on observation, interview and record review, the facility failed to develop a comprehensive care plan for 2 of the 15 sampled residents reviewed (#26 and #18) for activities. Findings included: - Review of resident #26 physician orders, dated 11/4/15, documented the resident admitted on 7/1/13, with the following diagnoses: Down's Syndrome (chromosomal abnormality characterized by varying degrees of mental retardation and multiple defect), blindness, and dementia (progressive mental disorder characterized by failing memory, confusion) with behavior disorder.	F 279		

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F 279	Continued From page 19 The annual MDS (minimum data set), dated 7/9/14, revealed the resident had highly impaired vision, and wore corrective lenses. The resident with short/long term memory problem, and severely impaired decision making. The resident interview for activity preferences revealed the resident determined it was very important to listen to music he/she liked, be around animals, such as pets, do things with groups of people, do the residents favorite activities, go outside to get fresh air when the weather is good, and participate in religious services or practices; and was not important to have books, newspapers, and magazines to read, and keep up with the news. The resident required extensive staff assistance for walking and locomotion; limited staff assistance for transfers and used wheelchair for mobility. The CAA (care area assessment), dated 7/15/14 for cognition documented the resident with a diagnosis of Downs Syndrome and associated dementia. The resident has been showing the ability to recall some of the staff names. Dementia is associated with Down's syndrome in later years of life, and can expect to see a continued decline. The CAA for vision revealed the resident is legally blind, however the resident can see outlines and shapes, but not much else. The CAA for ADL's included the resident required guidance with transfers and ambulation. The CAA for Activities did not trigger. The quarterly MDS, dated 10/9/14, revealed no changes from the prior MDS. The care plan, reviewed on 10/14/14, advised for impaired memory to provide task segmentation for the resident to allow completion of direction.	F 279		

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The care plan lacked a individualized activities for this resident with special needs related to blindness and Down's syndrome.

Review of the initial activity assessment, dated 7/9/13, documented the resident's past activity interest was music, watching television, enjoys older cartoons and older television shows. The resident was kind of a loner, his/her hobby used to be an Elvis fan, movies, and cartoons. Current Activity Interests: music, and watching television. Activity time preferences: the resident was a late riser, and prefers activities in activity room.

Review of the quarterly Activity Assessment, dated 1/21/14, documented the resident does participate in pen pal time. The resident was unable to do arts and crafts himself/herself but does appear to enjoy the interaction of being with others while these activities are being performed. The resident participated in bingo, during weekly bingo the auxiliary volunteer staff will work one on one in helping the resident play bingo. The resident appears to enjoy this activity. The resident participated in resident council, care plan meetings, and bible study. The resident participated in outings (a van ride). Furthermore, special meals or dinner parties at the facility, birthday parties, and holiday dinner. The resident will participate in sports exercise. For spiritual/religious activity, the resident enjoys gospel music. The resident participated in other activities: one to one, independent activities, and men's coffee. The resident appears to enjoy spending time with the facility bunny rabbit. The facility purchased a new CD (compact disc) player for his/her room. The resident appeared to enjoy the interaction with staff in a very positive way. Volunteer/Staff Services: hair care, manicures, grooming, and shopping. Factors

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Affecting Participation: illness, vision, and cognition. For behavior: when the resident first came to live here he/she had many different behavior issues. The resident now laughs and appears to be very happy.

The December 2014 Activity Calendar documented the following activities:

On 12/15/14, one on one exercises (no time listed),
At 10:00 AM, bingo, and 1 on 1 exercises today, the resident was in his/her room.
At 1:30 PM, one on one visits, the resident in his/her room.
At 2:30 PM bible study, and at 3:00 PM small group, the resident was in his/her room.

On 12/16/14, one on one exercises (no time listed), and card bingo at 9:30 AM, the resident was in his room.
At 10:30 AM, large group exercises, the resident was in his/her room.

On 12/15/14 at 10:00 AM, a group played bingo in the dining area, the the resident was not included in the group. Furthermore, the resident was not included in the one on one activities at 1:30 PM, or the group activity for bible study at 2:30 PM.

On 12/16/14 at 9:14 AM, the resident observed in his/her wheelchair in his/her room, in front of a bedside tablet holding a stuff animal. The door to the residents room was halfway closed and the resident's CD player not turned on. At 10:26 AM, the resident remained unchanged.

On 12/16/14 at 2:20 PM, the resident sitting in front of the window in his/her wheelchair holding a stuffed cat in his/her hand. The resident's side of

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F 279	Continued From page 22 the room contained a CD player, approximately 10 CD's, and also numerous DVD 's and a set of head phones lying beside the bed. The CD player was not turned on. On 12/16/14 at 3:40 PM, the resident back in his/her room, in his/her wheelchair, in front of the window holding a stuffed cat, and at 4:15 PM, the resident remained unchanged from the previous observation. On 12/17/14 at 8:30 AM, the resident sat in his/her room in front of a bedside table in a wheelchair, holding a stuffed cat. There was not any music playing, and at 9:30 AM, and 10:19 AM no change in the resident.. On 12/16/2014 at 12:52 PM, activity staff C stated he/she visited with the resident and his/her family members to see what his/her life was like. The resident's family member informed staff the resident liked to watch Walt Disney movies, however the resident can become excitable and may need taken out sometimes. The staff tries to adapt games for the resident. Staff C stated he/she tries to remember to chart if a resident attended an activity, but if not, he/she will document in the quarterly assessment. The resident likes to hold the facility rabbit, and the facility recently bought for the resident a new stuffed animal and a CD play to listen to music. Staff C stated he/she has a volunteer who will spend time with the resident and he/she does one on ones 2 times a week. The staff know what to do for the resident from the care plan. On 12/16/2014 at 2:20 PM, the resident answered yes when asked if he/she liked to sit in the sun, and does like to listen to music, however was unable to state what kind of music, the	F 279		

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F 279	Continued From page 23 resident liked. On 12/16/2014 2:25 at PM, direct care staff J stated the resident will usually let us know what activities he/she likes or dislikes. The resident does not come out for bingo,but will come out for singing, during church. Sometimes the resident comes out for exercises and then becomes over stimulated and will have to bring the resident back to his/her room. The resident usually or his/her roommate will usually have the radio on, today though neither one has the radio on. The resident has a care plan, and if the care plan is new the staff reads through it and signs it. On 12/16/2014 at 12:53 PM, activity staff C stated when a resident is admitted to the facility, I will do an initial assessment, then quarterly and yearly assessment. I will ask the resident and their family what the resident likes, and what his/her normal routine in regards to activities. Staff C does not chart daily on what the residents are participating in, he/she only charts on the quarterly and yearly assessment. On 12/16/2014 at 1:47 PM, direct care staff D reported a resident wants to go to an activity, the direct care staff will make sure the resident was dressed and toileted. If the resident wanted a specific activity on another shift, the staff would communicate that information during shift change report. A CNA (certified nurses aide) on the floor will do the activity if the AD (activity director) is not able to. On 12/17/14 at 8:45 AM, activity staff C stated he/she did an assessment in January, 2014, and the resident was due for an annual assessment in July, 2014, however he/she evidently did not do one. Furthermore, staff C does quarterly	F 279		

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assessments when administrative nursing staff A gives him/her a schedule of when they are due.

On 12/17/14 at 10:44 AM, direct care staff E stated the resident will hold his/her stuffed animal, likes to look out the window. Staff E will turn on music for the resident. Furthermore, staff E knows what to do for the resident from the care plan and the resident will ask the resident.

On 12/17/2014 at 9:12 AM, activity staff C stated the resident did not receive any one on one on 12/16/14.

On 12/16/2014 at 2:47 PM licensed nursing staff B stated the resident likes the rabbit, but can not place the resident too close to the rabbit because of a allergy. The resident likes to listen to music.

On 12/17/14 at 8:42 AM, administrative nursing staff A state he/she did not see any further activities assessments in the computer, nor is there a care plan for activities because the activity CAA did not trigger. Furthermore, stated the facility has 30 residents, the CNA's know of activities by word of mouth or the communication book.

On 12/17/2014 at 2:06 PM, licensed nursing staff N stated the resident held stuffed animals, and plays a lot of music, especially at night. The resident will come out for singing activities. The residents roommate has the radio on every night. The staff also open the blinds for the resident to look out. Staff N verified he/she reviewed the care plan and they are updated.

The undated facility Comprehensive Assessment and Care planning Policy, documented for scheduling the care plan will be completed on

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F 279	Continued From page 25 admission (within 14 days). An individual care plan will be developed/reviewed for each resident with documented measurable goals and outcomes within 7 days from completion of their MDS assessment. The RAI (resident assessment indicator) process (MDS & CAAS) is the basis for care plan decision making. This decision will be made by the RN (registered nurse) coordinator but is a combined effort of the members of the interdisciplinary team. The facility failed to develop a individualized comprehensive care plan to include care for this resident for activities. - Review of the physician order sheet, dated 11-07-14, revealed resident #18, admitted to the facility, on 9-15-11. The Significant Change MDS (minimum data set), dated 5-31-14, revealed the resident unable to complete a BIMS (brief interview for mental status). The staff interview revealed the resident with memory problems of both short and long term memory loss. The MDS also revealed it is very important to have family or a close friend involved in discussions regarding care, to listen to music and to do things with groups of people. The resident required total dependence of two staff for bed mobility, transfers and dressing. The CAA's (care area assessment), dated 5-31-14, did not trigger activities. The care plan, dated 12-03-14, directed staff to bring the resident to large group exercise for social interaction. However, the plan lacked any individualized activities for this resident.	F 279		

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F 279	Continued From page 26 The quarterly activity assessment, dated 9-24-14, documented the resident participated in arts and crafts and also enjoys pen pals (a group of fifth graders who visit the residents) are at the facility. On 12-15-14 at 11:50 a.m., the resident was resting in bed in his/her room while a group activity of ball toss proceeded the dining room. According to direct care staff F, the resident had not been invited to participate in the activity. On 12-16-14 at 3:30 p.m., the resident was resting in bed with eyes closed, while a group activity is going on in the dining room. The resident's television was tuned to a game show. On 12-16-14 at 10:24 a.m., direct care staff K stated, the resident no longer participated in group activities and does not do activities in his/her room. On 12-17-14 at 11:15 a.m., the resident's family member stated they would like for the television in the resident's room to be left on the Hallmark channel. On 12-16-14 at 12:53 p.m., activity staff C stated, the facility does an initial activity assessment at the time of a resident's admission. Staff C stated she will visit with the resident or their families to see what it is the resident enjoyed doing and will adapt games to fit the resident's needs. After that, quarterly assessments are done. Staff C continued to state that staff do not chart each activity a resident does each day, but it will often be added to the quarterly or yearly assessment. On 12-17-14 at 12:59 p.m., direct care staff D stated, the resident does not participate in	F 279		

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F 279	Continued From page 27 activities outside of his/her room. On 12-18-14, at 8:05 a.m., administrative nursing staff A, confirmed activities were not being documented on a daily basis and that there should have been a quarterly activity assessment done in March 2014. Staff A stated that if the facility documented activities daily, it would help to make the MDS and care plan more accurate for the resident. He/she continued to state the facility should explore more options for this resident's activities care planning to be more specific to his/her needs and desires. The facility policy, effective 10-19-14, included that each resident will be assessed upon admission, and a minimum of quarterly during the comprehensive assessment. This assessment will determine the amount and types of interests and activities that the resident currently pursues. In addition, it will assess the resident's preferred activity settings, and which activities the resident would prefer to participate in (independently or with others). Once this is done, an individual activity plan will be developed. The facility failed to develop this dependent resident's plan of care to include individualized activities.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the	F 280		

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comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This Requirement is not met as evidenced by:
The facility identified a census of 27 residents. The sample included 14 residents. Based on observation, record review and interview, the facility filed to review and revise the care plan for 1 (#12) of the sampled resident for activities and accidents.

Findings included:

- Review of resident #12 's physician order sheet, dated 11-4-14, revealed diagnoses including: Alzheimer disease (progressive mental deterioration characterized by confusion and memory failure), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), and HTN (Hypertension- elevated blood pressure).

The resident's annual MDS (minimum data set), dated 11/4/14, revealed the resident assessed with adequate hearing and vision, BIMS (Brief interview of mental status) score of 6, indicating

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moderately impaired cognition, mood score of 4 indicating minimal depression, wandered daily and intruded on the privacy of others. Family interview revealed it was not very important for the resident to read books, newspapers or magazines, somewhat important to listen to music, doing things with groups of people and participate in religious services and very important to be around animals such as pets, doing his/her favorite activities, go outside to get fresh air when the weather was good, and not important to keep up with the news. The resident was independent with bed mobility, required supervision with transfers, and required limited assistance of 2 staff with walking, ambulation, and dressing.

The MDS did not trigger for activities from the assessment dated on 11/4/14.

The residents CAA (care area assessment) for cognitive loss/dementia, dated on 11/8/14, revealed the resident had a diagnosis of Alzheimer disease and had moderate/severe cognition impairment. The resident wanders in the wheelchair most of the time. The resident had past history of behaviors such as striking and insulting others, but had not been an issue for at least last 90 days.

The plan of care, updated on 11/14/14, revealed the resident needed task segmentation to allow completion, reorientation to surroundings PRN (as necessary, attend morning announcements for orientation and staff was advised to redirect the resident if displaying frustration, behaviors or agitation. staff advised to do activities with the resident to decrease the risk of anxiety and wandering and encourage the resident to attended activities that the resident particularly

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enjoy, provide room visits when the resident was not going to activities, respect the residents right to refuse, and offer activities as choices between two events. The quarterly activity assessment will be documented to update the resident ' s interests. Encourage the resident to attend activities like silverware wrapping and others which he/she might appear to be able to volunteer his/her services.

The activity calendar for December 16, 2014 revealed the following activities:

One on one exercises un-timed, this resident was in bed.
9:30 AM - card bingo, this resident was in bed.
10:30 AM - Large group exercises, the resident refused to go due to getting up out of bed at this time.
1:30 PM- Care plans.
3:00 PM - Ball toss, the resident refused.

Activites on 12/17/14, included the following activities :

9:30 AM small group (B &D), the resident was in bed.
Un-timed, one and one activity, the resident was in bed.
Un-timed, nail care, the resident was in bed.
Un-timed mini fit group, the resident was in bed.
2:00 PM - Silverware wrapping.
3:00 PM - Lets sing Christmas music and decorate Christmas cookies.
3:00 PM - small group (A&C).

The activity assessment, dated on 11/13/14, revealed past activity interests of cards, rummy, games, Chinese checkers, crafts/arts, woodworking, sports, swimming, music, religious

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activity, watching TV, current activity interest are cards, visiting possibly one on one, music walking outdoors, watching TV. activity time preferences are in the morning, the resident likes to get up early in the morning, and prefer outside activities.

The residents clinical record lacked any quarterly activity assessments since admission that was confirmed by administrative nursing staff A.

On 12/17/2014 at 2:22 PM, the resident was sitting at the front door, looking out the door while the silverware wrapping was in progress in the dining room.

On 12/17/14 at 3:15 PM, the resident is wandering the halls in his/her wheelchair, propelling him/herself while the Christmas music and cookie decorating was in progress in the dining room.

On 12/17/2014 at 1:19 PM, the resident's family member, stated the residents cognition had declined, and he/she was not interested in doing what he/she used to do. Activity staff C tried to engage the resident, but activity staff C needed a full time assistant to help with the activities.

On 12/16/2014 at 12:53 PM, activity staff C, stated when the resident was admitted to the facility, he/she will do an initial assessment, then quarterly and yearly assessment. He/she will ask the resident and their family what the resident likes and what their normal routine in regards to activities. He/she does not chart daily on what the residents are participating in. He/she only chart quarterly and yearly. He/she tries get to engage the resident in anything. The resident does not stay engaged for very long. The resident will set and watch someone else do activities but will not

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participate. The resident likes to go up and down the halls in the wheelchair. The resident does not seem interested in anything. The staff have tried to reminisce, look at picture books and go through a trinket box. The resident is very sensitive with his/her hearing. The resident likes to lay down a lot. It varies on how often he/she participate. The staff will ask him/her and encourage him/her to come to activities. The resident does not like to be in his/her room unless he/she was sleeping.

On 12/18/2014 at 8:43 AM, activity staff C, stated he/she had no excuse for why the quarterly did not get done. He/she think that it was more important to assist the aides on the floor then to get the paper work done. He/she really did not have any time to do the assessments, between the scheduled activities, transportation and assisting on the floor, he/she could not keep caught up on them.

On 12/16/2014 at 1:47 PM, direct care staff D, stated If the resident wants to go to an activity, the staff will make sure the resident was up, dressed and toileted. If the resident wanted a specific activity on another shift, the staff would communicate that in shift change report. The resident needs direction to the activity, he/she likes wandering in his/her wheelchair. Staff D stated the resident loses interest and has to be directed to the activity. The resident likes putting together puzzle and can get very irritated and confused. The resident was invited to the activities, but he/she will not stay. There are no activities to keep his/her attention with the activities, the only time was when his/her family was here.

On 12/17/2014 at 2:56 PM, direct care staff G,

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stated the resident will come out to the movies, the staff assisted the resident to the activities. The resident does not refuse the activities unless he/she was asleep. The staff will go to the residents room and ask the resident if he/she would like to attend the activity.

On 12/18/2014 at 9:46 AM, direct care staff M, stated the staff will take him/her into the activity, but then he/she will leave. The residents attention span was very short. The resident wanders most of the time. The staff asked the resident to come to every activity. The resident will come and not stay long.

On 12/16/2014 at 2:47 PM, licensed nursing staff B stated the resident has a very short attention span. The resident had dementia and it was hard for the resident to pay attention. The resident really likes pop corn and watching a movie. If the resident refuses anything he/she had the staff tell the nurse, so that another approach could be tried with the resident. The staff made sure that auxiliary staff was to assist with activities, when there was a big activity, he/she will schedule a CNA on the floor to assist and leave 2 staff on the floor to answer the call lights when the activity department needed assistance.

On 12/17/2014 at 3:09 PM, licensed nursing staff N, stated the resident has a short attention span, the staff will take the resident to the activity and with in a couple of minutes the resident will leave. The resident enjoys church and singing. The staff will let the residents know when an activity was going on. The resident wanders all the time. The resident will be up late at night wandering, then the resident will sleep all day.

On 12/17/2014 at 12:09 PM, administrative

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nursing staff A, stated he/she was able to find the resident ' s initial assessment from the residents admission, but he/she could not find any evidence of any quarterly activity assessment. The activity director needs to be charting that the residents are participating in an activity quarterly and daily. The quarterly assessments should be done when the care plan meeting was being discussed.

Furthermore, review of the resident's clinical record, revealed the lack of care plan revision with fall interventions following falls on 5/4/14 and 12/1/14, for the resident.

The residents quarterly MDS (minimum dated set), dated on 2/5/14, revealed a 1 non injury fall since the last assessment, wandered daily and intruded on the privacy of activities of others. The resident was independent with bed mobility, supervision with transfers, limited assistance of 1 staff with walking, ambulation, and toileting. The resident had 1 non injury fall since the prior assessment dated on 8/4/14, the resident was on antipsychotic, antianxiety and antidepressant medications.

The residents quarterly MDS, dated on 5/6/14, reveled the resident had limited assistance of 1 staff with transfers and had 1 non injury fall since the last assessment dated on 2/5/14. There are not further changes from the previous assessment.

The residents quarterly MDS, dated on 8/4/14, revealed a BIMS (brief interview of mental status) score of 99. The resident had short term and long term memory problems. The resident had 1 non injury fall since the last assessment dated on 5/6/14. There are not any further changes from

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F 280	Continued From page 35 the previous on assessment. The residents annual MDS, dated on 11/4/14, revealed the resident had 1 non injury fall since the prior assessment dated on 8/4/14. The residents CAA (care assessment area) for Falls, dated 11/8/14,revealed the resident had a history of falls prior to admission. The last fall was documented on 8/29/14. Most of the issue was related to safety awareness and poor judgement on his/her part to use, a walker with ambulation. The resident was on a wireless personal alarm to help alert staff of his/her movements and to decrease the residents falls or injury. The resident does not use his/her call light to report needs, but will try to do it on his/her own. The resident required staff assistance to ambulate safely and provide cueing to keep the walker in front of him/her. The resident was a high risk for falling and injuries. The plan of care, updated 11/14/14, revealed the resident needed task segmentation to allow completion of directions and reorient to surroundings PRN (as necessary). The resident was to attend morning announcements for orientation and redirect the resident if displaying frustration or behaviors to decrease agitation. The task segmentation to allow completion of directions, reorient the resident to his/her surroundings PRN, have the resident attend morning announcements for orientation, redirect the resident if displaying frustration or behaviors to degrees agitation. The resident self propels in a wheelchair throughout the facility, but does not present as an elopement risk at this time. The resident was entering other resident's rooms and restrooms and required redirection from staff. The staff are to continue to monitor him/her	F 280		

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closely. The resident had a potential for injury due to unsteady gait/weakness. The staff are to keep the environment free of clutter, the bed at the lowest position and locked, bed control in reach at all times. The resident required 1 staff for transfers and ambulation, and is independent in a wheelchair. The resident was to have a fall risk assessment quarterly, a falling star magnet on the residents door, the side rails are to be up on the right side of his/her bed per resident request for mobility assessment. Monitor for SE (side effects) of medications, pressure alarm in wheelchair, bed and recliner, and check pressure alarm function every shift. The resident had been standing up and ambulating unassisted even with the alarm. The staff provided rapid response to alarms and provide contact guard assist with most transfers/ambulation. The resident has a self care deficit related to dementia. The resident can transfer and ambulate with a walker with a gait belt and assistance of 1 staff. Encourage completion of dressing and daily hygiene. The call light was to be in reach at all times. Toilet and reposition the resident every 2 hours and PRN. The staff was to assist with completion of dressing and daily hygiene, pericare and change brief, moisture barrier per each incontinent episode.

The plan of care lacked interventions for the resident's fall on 5/4/14.

The facility complaint investigation, dated 5/4/14, revealed the resident was found on the floor in his/her room at the foot of the bed. The residents personal alarm failed to sound, to alerting the staff of the resident movement. The safety key was positioned over the reset icon on the alarm box causing the alarm to shut off without sounding. The fall was without injury. The staff

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was instructed to not leave the key in place on the alarm boxes to prevent malfunctioning of the device.

The plan of care, updated on 8/29/14, included a fall in the lobby on 8/29/14, when he/she attempted to ambulate without assistance. The resident had a personal alarm in bed and in the wheelchair to alert staff of his/her movements.

The facility complaint investigation, dated 8/29/14, revealed a non injury fall. The staff responded to a personal pressure alarm sounding and found the resident sitting in the commons area between his/her wheelchair unlocked and the couch. The staff provided frequent reminders to the resident to ask for staff assistance prior to transferring, and frequent reminders to lock the wheels of the wheelchair before transferring. However, this intervention would not be appropriate for a confused, forgetful resident with repeated fall.

The facility lacked interventions for the resident's fall on 12/1/14.

The facility complaint investigation, dated 12/1/14, revealed the resident stood up from the wheelchair and lost his/her balance and fell. The personal alarm sounded late, related to it being under the cushion and delayed its signal. The new intervention per administrative staff A, instructed the charge nurse, licensed nursing staff M, to conduct two or more sets of orthostatic blood pressures spread out to monitor if there was a change relating to lying down and standing up quickly or if he/she was suffering from hypotensive drops. The care plan will be charged back to placing the wheelchair alarm pad on top of the cushion to minimize risk of delaying the sound. However, this intervention lacked

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communication to the staff with failure to be included on the care plan.

The fall risk assessment quarterly, dated 4/26/14, revealed a score of 11, indicating the resident is a high fall risk

The fall assessment, dated on 7/23/14, revealed a score of 12, indicating the resident is a high fall risk.

Observation on 12/15/2014 at 4:01 PM, revealed the resident was resting in bed with his/her eyes closed. Both of the half side rails were up. The resident was laying on his/her right side in the bed. The resident has a wireless pressure alarm under the right hip, turned on.

Observation on 12/16/2014 at 1:43 PM, the resident was sitting in his/her wheelchair with the pressure alarm engaged, propelling him/herself down the hall and was looking out the door at the end of the west hall.

Interview on 12/17/2014 at 1:19 PM, with the resident's family member, revealed the resident does not remember to ask for help. He/She has brought in a lot of non skid socks. He/She requested placement of the alarm put under the cushion of the wheelchair, but now it was on the top of the cushion.

On 12/17/2014 at 2:49 PM, direct care staff G, stated the pressure alarms are to be in any seats and bed and the resident was to always have non skid socks. The alarm is to be under the big cushion on the chair. The resident is cognitively impaired. He/She thinks the resident is too independent to push the call light and ask for help. The resident is unable to remember

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anything for very short amount of time. Chances are the resident is not going to remember to use the call light. When checking the pressure alarm, push down before the resident uses it. He/She was not aware of any where that the staff charts the checking of the alarms. He/She did not think reminding the resident to use the call light was an appropriate intervention for falls.

On 12/18/2014 at 9:45 AM, direct care staff M, stated when the resident gets into the chair the staff will push on the pad to make the alarm go off. The alarm was to be right under the resident's bottom. The resident will not use the call light no matter how much the staff reminds the resident. The resident had non skid socks that are on all the time.

On 12/17/2014 at 2:59 PM, licensed nursing staff N, stated the resident was very independent and does things for himself/herself. The resident does not sleep well at night and wanders a lot, then likes to sleep in. The alarm pad was to be on the top of the cushion. The alarm was being charted in the computer system. The nurses monitor the positioning of the alarm. The resident was to have slipper socks on at all times. The nurses also monitor the slipper socks to make sure that the socks are on. The resident was cognitive impaired, the intervention to remind the resident to use the call light was not appropriate intervention for the resident.

On 12/17/2014 at 3:15 PM, administrative nursing staff A, stated the resident did not have the interventions for the May 2014 fall and December 2014 fall due to he/she had provided staff education on fall prevention for this resident for the May 2014 fall The December fall intervention was to put the pad alarm on top of the cushion.

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F 280	Continued From page 40 The resident tends to kick off his/her slipper socks in the bed. He/she did fail to put the intervention on the care plan for the 12/1/14 fall. An intervention to remind the resident to use the call light and ask for assistance. He/she reviews the medications with a fall if it was indicated that the fall could of been from one of the medications that the resident was on. He/she does not routinely review the residents medications on fall investigations. The facility failed to review and revise this resident's care plan to include individualized activities and interventions following falls to prevent repeated falls for this dependent resident.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility had a census of 27 residents. The sample included 14 residents with 3 reviewed for accidents. Based upon observation, record review and interview, the facility failed to implement interventions to prevent repeated falls for 1 (#12) of the 3 sampled residents. Findings included: - The resident (#12) diagnoses when admitted on 10/25/13, found on the signed POS (physician order sheet) dated on 11/4/14, included:	F 323		

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F 323	Continued From page 41 Alzheimer disease (progressive mental deterioration characterized by confusion and memory failure), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), ostroarthritis (degenerative changes to one or many joints characterized by swelling and pain), and HTN (Hypertension- elevated blood pressure). The residents quarterly MDS (minimum dated set), dated on 2/5/14, revealed a 1 non injury fall since the last assessment, revealed a BIMS (brief interview of mental status) score of 99. The resident had short term and long term memory problems. The resident wandered daily and intruded on the privacy of activities of others. The resident was independent with bed mobility, supervision with transfers, limited assistance of 1 staff with walking, ambulation, dressing, and toileting. The resident had no pain indicators noted on assessment. The resident had 1 non injury fall since the prior assessment dated on 8/4/14, the resident was on antipsychotic, antianxiety and antidepressant medications. The residents quarterly MDS, dated on 5/6/14, reveled the resident had limited assistance of 1 staff with transfers and had a 1 non injury fall since the last assessment dated on 2/5/14. There are not further changes from the previous assessment. The residents quarterly MDS, dated on 8/4/14, revealed a BIMS (brief interview of mental status) score of 99. The resident had short term and long term memory problems. The resident had 1 non injury fall since the last assessment dated on 5/6/14. There are not any further changes from the previous on assessment.	F 323		

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The residents annual MDS, dated on 11/4/14, revealed the resident had a BIMS (Brief interview of mental status) score of 6, indicating that the resident had moderately impaired cognition. The resident had 1 non injury fall since the prior assessment dated on 8/4/14.

The residents CAA (care assessment area) for cognitive loss/dementia, dated 11/8/14, revealed the resident had a diagnosis of Alzheimer disease and had moderate/severe cognition impairment. The resident demonstrated poor judgement with regards to safety and ambulation. The resident wanders in the wheelchair most of the time. The resident had past history of behaviors such as striking and insulting others, but the behaviors had not been an issue for at least last 90 days. The resident was a high risk for falling related to poor safety awareness, wandering and elopement risk.

The residents CAA (care assessment area) for functional status, dated 11/8/14,revealed the resident had a diagnosis of Alzheimer disease and requires assistance to ambulate safely. The resident had a history of falling at home prior to admission related to poor judgement and lack of consistent use of safety devices for locomotion. The resident requires cueing and task segmentation to stay on track with activities such as dressing and hygiene. The resident wanders the hallways in his/her wheelchair and had some issue with entering other resident rooms. The resident was at risk for falling related to the need for supervision and assistance.

The residents CAA (care assessment area) for Behavioral symptoms, dated 11/8/14, revealed the resident had some behavioral issues with

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wandering and invading other resident private spaces. The staff will attempt to redirect and meet basic needs to ensure this was not related to toileting, and pain. The resident is on seroquel, 25 mg (milligram), twice a day, which had been decreased from three times a day on 11/4/14, for behaviors and since his/her issues have decreased. The facility was trying a GDR (gradual dose reduction) with the resident.

The residents CAA (care assessment area) for Falls, dated 11/8/14,revealed the resident had a history of falls prior to admission. The last fall was documented on 8/29/14. Most of the issue was related to safety awareness and poor judgement on his/her part to use, a walker with ambulation. The resident was on a wireless personal alarm to help alert staff of his/her movements and to decrease the residents falls or injury. The resident does not use his/her call light to report needs, but will try to do it on his/her own. The resident required staff assistance to ambulate safely and provide cueing to keep the walker in front of him/her. The resident was a high risk for falling and injuries.

The plan of care, updated 11/14/14, revealed the resident needed task segmentation to allow completion of directions and reorient to surroundings PRN (as necessary). The resident was to attend morning announcements for orientation and redirect the resident if displaying frustration or behaviors to decrease agitation. The task segmentation to allow completion of directions, reorient the resident to his/her surroundings PRN, have the resident attend morning announcements for orientation, redirect the resident if displaying frustration or behaviors to degrees agitation. The resident self propels in a wheelchair throughout the facility, but does not

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present as an elopement risk at this time. The resident was entering other resident's rooms and restrooms and required redirection from staff. The staff are to continue to monitor him/her closely. The resident had a potential for injury due to unsteady gait/weakness. The staff are to keep the environment free of clutter, the bed at the lowest position and locked, bed control in reach at all times. The resident required 1 staff for transfers and ambulation, and is independent in a wheelchair. The resident was to have a fall risk assessment quarterly, a falling star magnet on the residents door, the side rails are to be up on the right side of his/her bed per resident request for mobility assessment. Monitor for SE (side effects) of medications, pressure alarm in wheelchair, bed and recliner, and check pressure alarm function every shift. The resident had been standing up and ambulating unassisted even with the alarm. The staff provided rapid response to alarms and provide contact guard assist with most transfers/ambulation. The resident has a self care deficit related to dementia. The resident can transfer and ambulate with a walker with a gait belt and assistance of 1 staff. Encourage completion of dressing and daily hygiene. The call light was to be in reach at all times. Toilet and reposition the resident every 2 hours and PRN. The staff was to assist with completion of dressing and daily hygiene, pericare and change brief, moisture barrier per each incontinent episode. Assist with dressing in the morning, he/she will try to put pajama pants on when dressing by self.

The plan of care lacked interventions for the fall on 5/4/14.

The facility complaint investigation, dated 5/4/14, revealed the resident was found on the floor in

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his/her room at the foot of the bed. The residents personal alarm failed to sound, to alerting the staff of the resident movement. The safety key was positioned over the reset icon on the alarm box causing the alarm to shut off without sounding. The fall was without injury. The staff was instructed to not leave the key in place on the alarm boxes to prevent malfunctioning of the device.

The plan of care, updated on 8/29/14, included a fall in the lobby on 8/29/14, when he/she attempted to ambulate without assistance. The resident had a personal alarm in bed and in the wheelchair to alert staff of his/her movements.

The facility complaint investigation, dated 8/29/14, revealed a non injury fall. The staff responded to a personal pressure alarm sounding and found the resident sitting in the commons area between his/her wheelchair unlocked and the couch. The staff provided frequent reminders to the resident to ask for staff assistance prior to transferring, and frequent reminders to lock the wheels of the wheelchair before transferring. However, this intervention would not be appropriate for a confused, forgetful resident with repeated fall.

The facility lacked interventions for the fall on 12/1/14.

The facility complaint investigation, dated 12/1/14, revealed the resident stood up from the wheelchair and lost his/her balance and fell. The personal alarm sounded late, related to it being under the cushion and delayed its signal. The new intervention per administrative staff A, instructed the charge nurse, licensed nursing staff M, to conduct two or more sets of orthostatic blood pressures spread out to monitor if there

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was a change relating to lying down and standing up quickly or if he/she was suffering from hypotensive drops. The care plan will be charged back to placing the wheelchair alarm pad on top of the cushion to minimize risk of delaying the sound. However, this intervention lacked communication to the staff with failure to be included on the care plan.

The fall risk assessment quarterly, dated 4/26/14, revealed a score of 11, indicating the resident is a high fall risk

The fall assessment, dated on 7/23/14, revealed a score of 12, indicating the resident is a high fall risk.

Observation on 12/15/2014 at 4:01 PM, revealed the resident was resting in bed with his/her eyes closed. Both of the half side rails were up. The resident was laying on his/her right side in the bed. The resident has a wireless pressure alarm under the right hip, turned on.

Observation on 12/16/2014 at 12:20 PM, revealed the resident was sitting at the dining room table waiting for lunch in the wheelchair with the wireless alarm on.

Observation on 12/16/2014 at 1:43 PM, the resident was sitting in his/her wheelchair with the pressure alarm engaged, propelling him/herself down the hall and was looking out the door at the end of the west hall.

Observation on 12/16/2014 at 2:30 PM, the resident was sitting in a chair in the entry way watching the birds in the bird cage. the resident is resting his/her feet in his/her wheelchair. The

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F 323	Continued From page 47 resident's alarm was under his/her buttock in the recliner. Interview on 12/17/2014 at 1:19 PM, with he resident's family member, revealed the resident does not remember to ask for help. He/She has brought in a lot of non skid socks. He/She requested placement of the alarm put under the cushion of the wheelchair, but now it was on the top of the cushion. On 12/17/2014 at 2:49 PM, direct care staff G, stated the pressure alarms are to be in any seats and bed and the resident was to always have non skid socks. The alarm is to be under the big cushion on the chair. The resident is cognitively impaired. He/She thinks the resident is too independent to push the call light and ask for help. The resident is unable to remember anything for very short amount of time. Chances are the resident is not going to remember to use the call light. When checking the pressure alarm, push down before the resident uses it. He/She was not aware of any where that the staff charts the checking of the alarms. He/She did not think reminding the resident to use the call light was an appropriate intervention for falls. On 12/18/2014 at 9:45 AM, direct care staff M, stated when the resident gets into the chair the staff will push on the pad to make the alarm go off. The alarm was to be right under the resident's bottom. The resident will not use the call light no matter how much the staff reminds the resident. The resident had non skid socks that are on all the time. On 12/17/2014 at 2:59 PM, licensed nursing staff N, stated the resident was very independent and does things for himself/herself. The resident does	F 323		

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not sleep well at night and wanders a lot, then likes to sleep in. The alarm pad was to be on the top of the cushion. The alarm was being charted in the computer system. The nurses monitor the positioning of the alarm. The resident was to have slipper socks on at all times. The nurses also monitor the slipper socks to make sure that the socks are on. The resident was cognitive impaired, the intervention to remind the resident to use the call light was not appropriate intervention for the resident.

On 12/17/2014 at 3:15 PM, administrative nursing staff A, stated the resident did not have the interventions for the May 2014 fall and December 2014 fall due to he/she had provided staff education on fall prevention for this resident for the May 2014 fall The December fall intervention was to put the pad alarm on top of the cushion. The resident tends to kick off his/her slipper socks in the bed. He/she did fail to put the intervention on the care plan for the 12/1/14 fall. An intervention to remind the resident to use the call light and ask for assistance. He/she reviews the medications with a fall if it was indicated that the fall could of been from one of the medications that the resident was on. He/she does not routinely review the residents medications on fall investigations.

The facility policy for falls, dated on 2/18/10, revealed the staff are to enter preventive measures into the resident's plan of care after a fall.

The facility failed to provide appropriate adequate interventions for this cognitively impaired resident who had 3 falls between 5/4/14 to 12/1/14 without effective interventions implemented.